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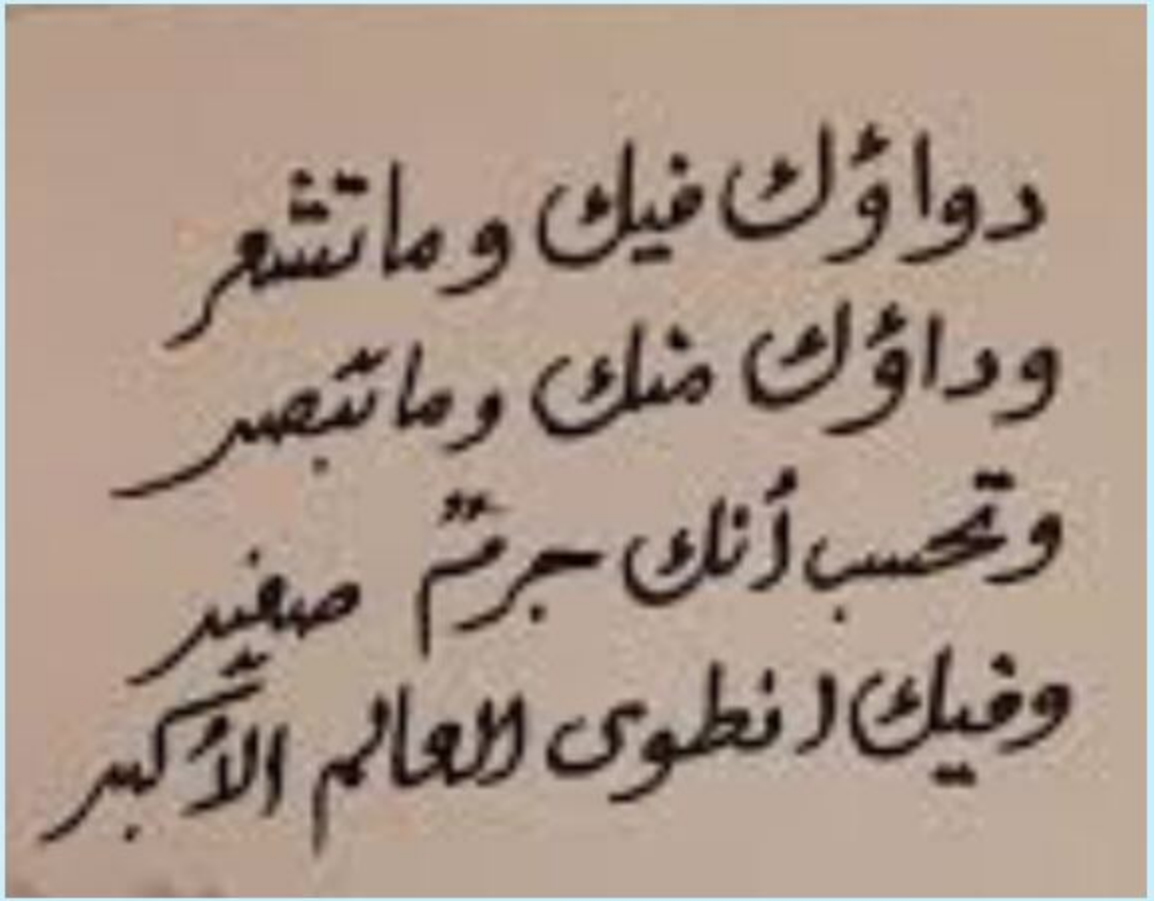

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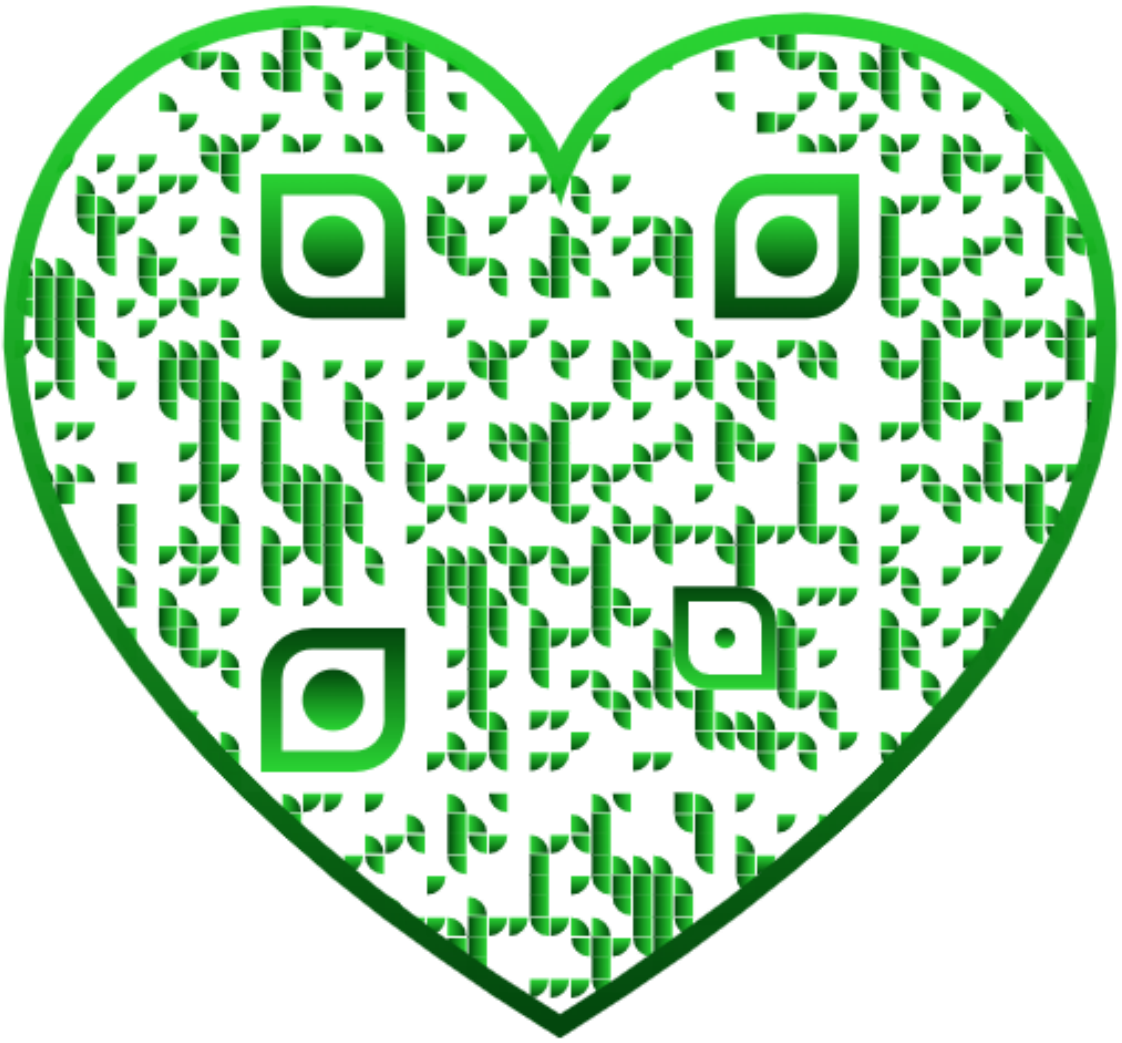

Figure 13-2 Typical appearance of eczematous dermatitis compatible with ACD. **A.** Note the erythematous scaly plaques with some fissuring on the hands. **B.** Erythematous papules, scattered on the extensor forearms. This is a typical picture of contact allergy to a skin care product ingredient.

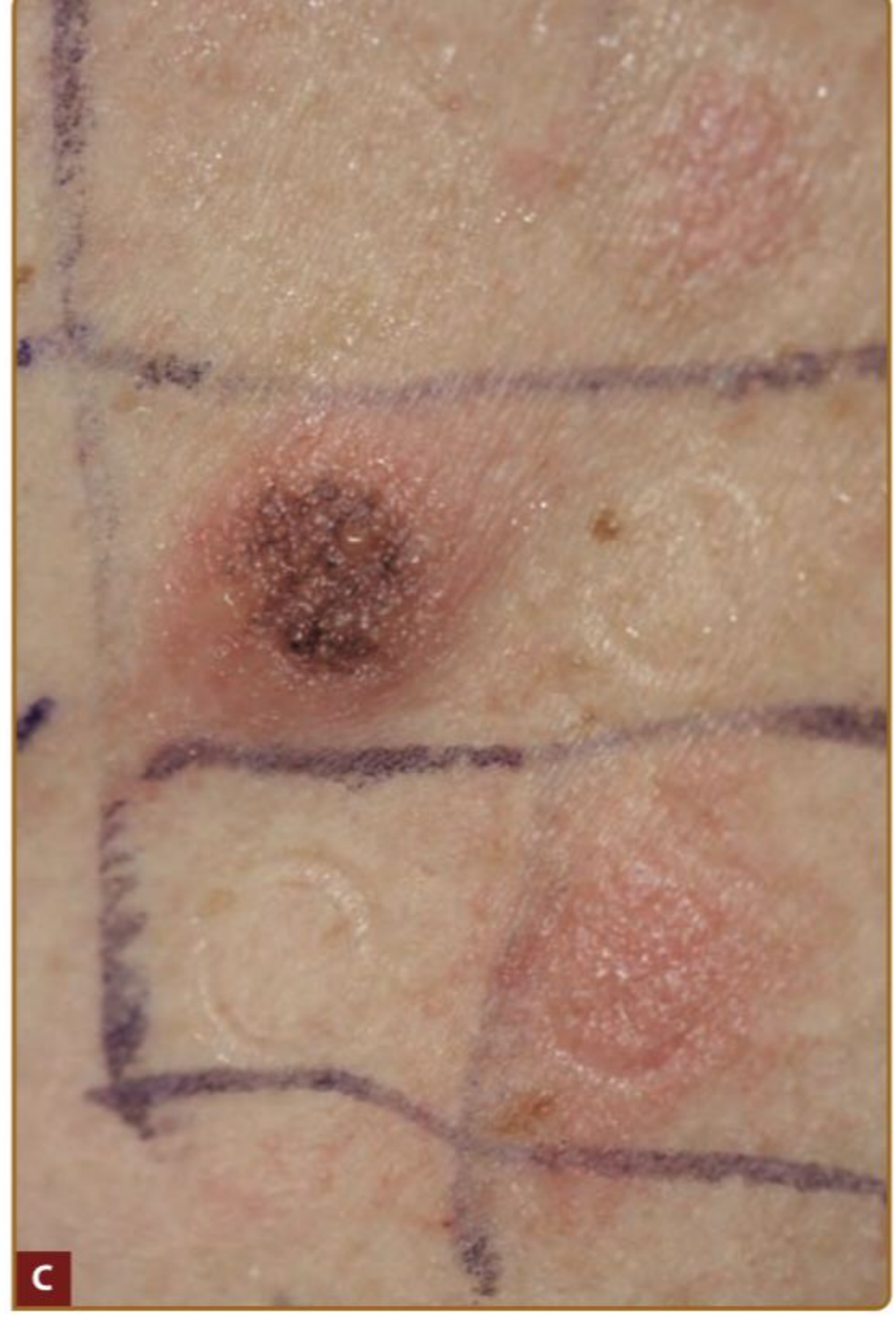

Figure 13-4 ACD to *para*-phenylenediamine. **A.** Notice the eczema on the distribution of the hairline and behind the ears. **B.** Dermatitis on the forehead where the bangs came in contact with the skin of the same patient. **C.** *para*-Phenylenediamine, the most frequent relevant allergen in hair dye, is a strong sensitizer. It will darken the patch-test site. There is a strong edematous and vesicular reaction that is spreading, a 3+ reaction to this patch test.

Figure 13-5 Allergic Contact Cheilitis. Fragrances and flavorings are top among the most common causes of contact allergy in patch-tested patients with cheilitis.

Figure 13-6 This eczematous dermatitis was caused
he most frequent preservative allergen, quaternium-
which was present in the patient's moisturizer.

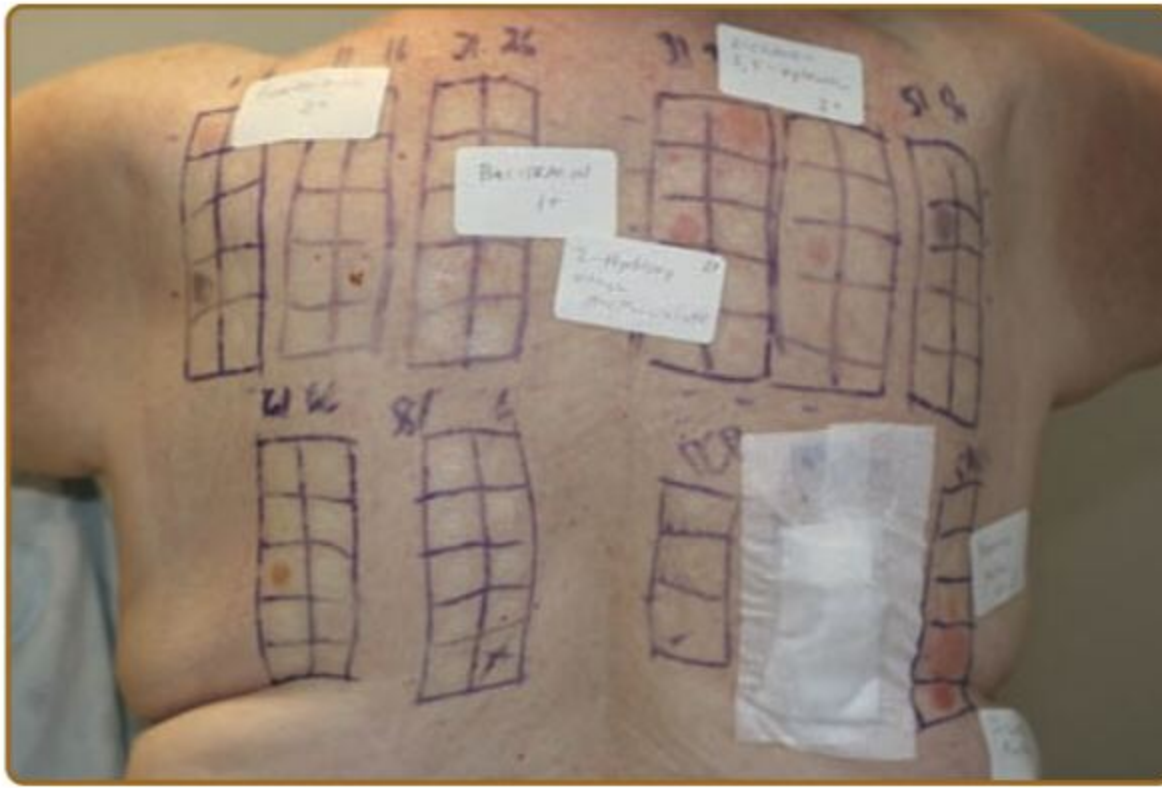

Figure 13-8 This patient had multiple relevant positive patch tests. Bacitracin, chloroxylenol, and 2-hydroxyethyl methacrylate are relevant to this patient's severe dermatitis but are not allergens on the currently available commercial screening series.

Figure 14-1 Ichthyosis vulgaris commonly accompanies atopic dermatitis and is thought to be responsible for the barrier defect in a subset of patients. Note the larger scales on the lower extremities.

Figure 14-5 **A.** Pronounced weeping and crusting of eczematous lesions in childhood atopic dermatitis. **B.** Excoriated papules and crusting (with secondary infection) in an acute flare of atopic dermatitis.

Figure 14-3 Prurigo papules in a patient with atopic dermatitis.

Figure 14-4 Lichenification and excoriations on the dorsal aspect of the hand in a child with atopic dermatitis

primarily involves the face (Fig. 14-8), scalp, and the extensor surfaces of the extremities (Fig. 14-9). The diaper area is usually spared. In older children, and in

Figure 14-2 Hyperlinear palms.

Figure 14-6 Confluent erythematous papules on th cheeks of an infant with subacute atopic dermatit Chronic exposure to saliva and moist food at this locatio has been thought to contribute to the distribution.

Figure 14-9 Itching infant with atopic dermatitis. (Use
with permission from Oholm Larsen, MD.)

Figure 14-10 Childhood atopic dermatitis with lichenification of antecubital fossae and generalized severely pruritic eczematous plaques.

Figure 14-12 Eczema herpeticum. Typical vesicles and crusting in a patient with disseminated disease.

Figure 15-1 Nummular eczema. Coin-shaped plaques with pinpoint erosions and excoriations. (Image from Division of Dermatology, University of the Witwatersrand, Johannesburg, South Africa, with permission, from Professor D. Modi.)

Figure 15-3 Nummular eczema in a child. Crusted plaque
(Used, with permission, from P. Lio, M.D., Northweste
University's Feinberg School of Medicine, Chicago.)

Figure 15-2 Nummular eczema. Single plaque showing pinpoint erosions and crusting.

Figure 16-2 Chronic dyshidrotic hand dermatitis of bilateral hands. There is hyperkeratosis of the palms and fingers sparing the dorsal hand. Deep-seated vesicles at different stages can be seen.

Figure 16-4 Cheiropompholyx. Apart from small vesicles, there are large bullae, some purulent; others have collapsed and are drying up.

Figure 16-5 Podopompholyx. Large blisters have ruptured leaving erosions that are drying up. Note large bulla on the arch of the right foot: The roof of the blister still contains tapioca-like vesicles. This is characteristic.

Figure 16-7 Id reaction to tinea pedis. Erythematous, partially dried up vesicles on the foot. Lesions are very pruritic.

Figure 16-6 Hyperkeratotic hand dermatitis. There are pruritic keratotic plaques on the central palm: Occasional vesiculation and fissuring may occur.

Figure 17-1 Stasis dermatitis with autosensitization. An elderly woman with a long-standing history of stasis dermatitis presented with gradual worsening of the edema; pruritus; and multiple, punctate, superficial, excoriated ulcers overlying the medial malleoli (**A**). Nine days after the ulcers appeared, she developed an acute, extremely pruritic, erythematous, papulovesicular eruption over the forearms (**B**), which progressively involved the upper arms, upper torso, and hands. The acute papulovesicular dermatitis also involved the lower extremities and can be noted overlying the chronic stasis dermatitis (**A**).

Figure 18-7 A–F. Chronic plaque psoriasis located at typical sites. Note marked symmetry of lesions. (Photos used with permission from Dr. Johann Gudjonsson and Mr. Harrold Carter.)

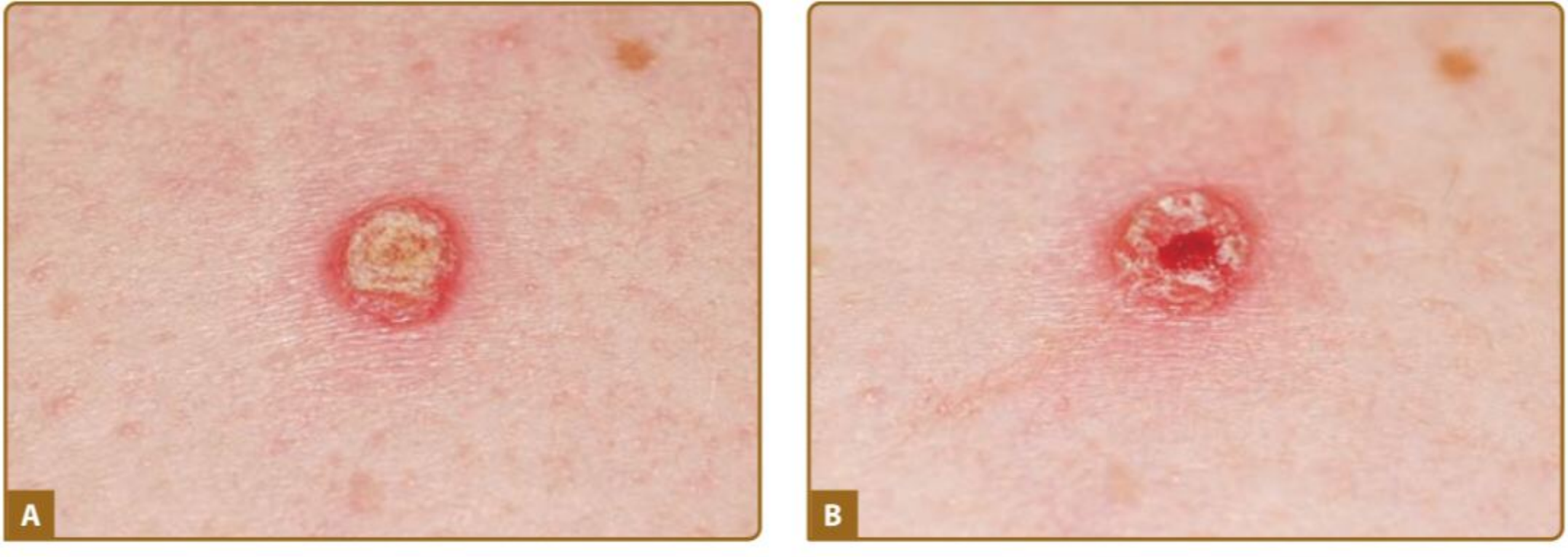

Figure 18-8 Auspitz sign. Note point of bleeding after scale is removed. (Photos used with permission from Dr. Johann Gudjonsson and Ms. Laura Vangoor.)

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Figure 18-10 Unusual forms of plaque-type psoriasis **A.** Annular psoriasis on the flank. **B.** Rupioid psoriasis in an infant. Note cone-shaped lesions. **C.** Psoriatic patient undergoing modified Goeckerman therapy (ultraviolet B light, coal tar, and topical steroid), demonstrating Woronoff rings. **D.** Elephantine psoriasis of the lower extremities. Note psoriatic involvement of toenails. (Photographs used with permission from Dr. Johann Gudjonsson, Mr. Harrold Carter, and Ms. Laura Vangoor.)

Figure 18-11 Guttate psoriasis, involving thigh (**A**), hands (**B**), and back (**C** and **D**). The patient in **D** went on to develop chronic plaque psoriasis. (Photos used with permission from Drs. Johann Gudjonsson and Trilokraj Tejasvi, Mr. Harrold Carter, and Ms. Laura Vangoor.)

Figure 18-9 Koebner phenomenon. **A.** Psoriasis appearing in keratome biopsy sites 4 weeks after biopsy. (Photo used with permission from Mr. Harrold Carter.) **B.** Flare of psoriasis on the back after a sunburn. Note sparing of sun-protected areas. (Photo used with permission from Dr. James Rasmussen.)

Figure 18-12 Flexural psoriasis. Note the well-demarcated, beefy-red, shiny plaques in **A**. The infant in **B** is suffering from "napkin psoriasis." (Photos used with permission from Dr. Johann Gudjonsson and Mr. Harrold Carter.)

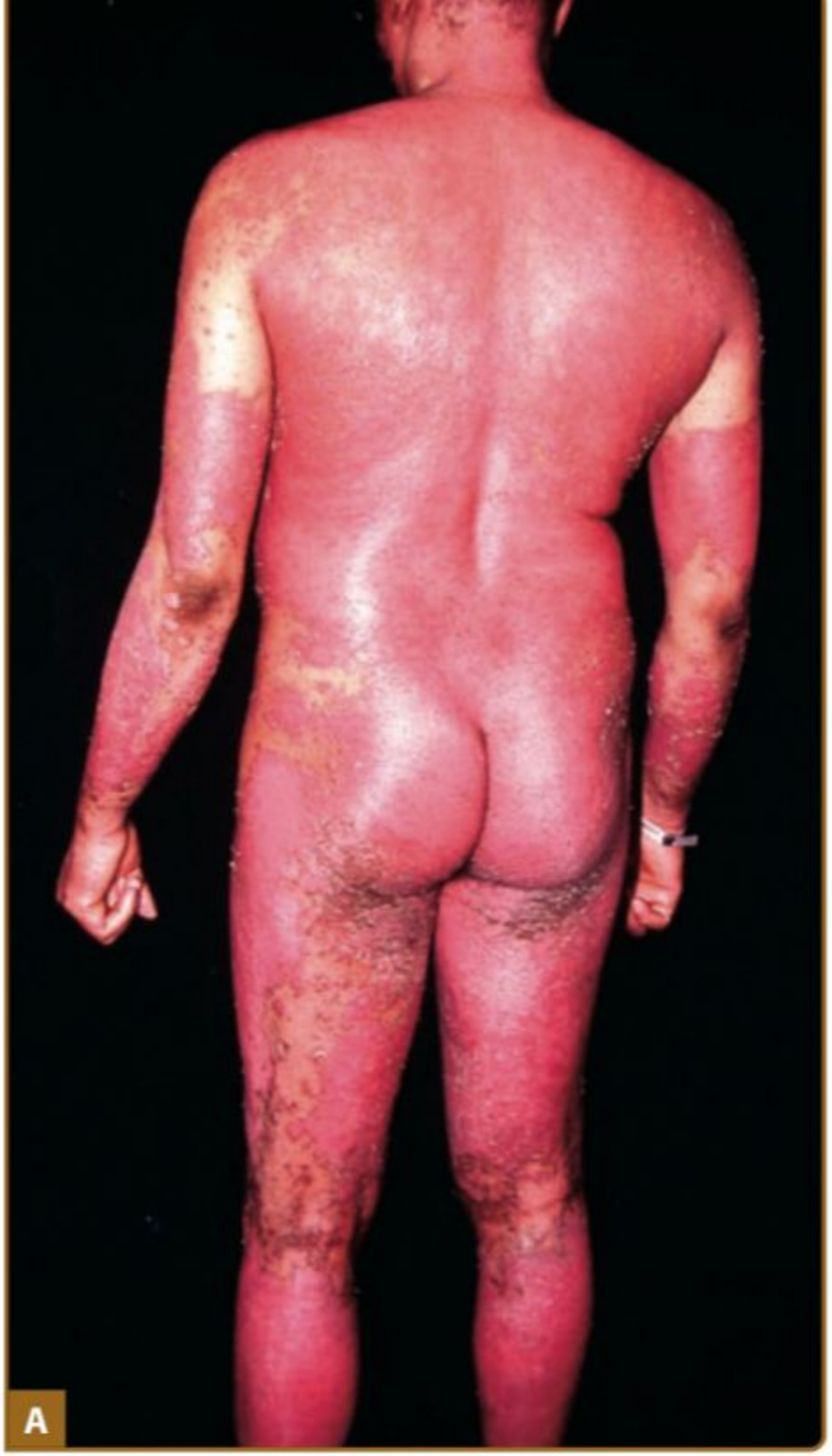
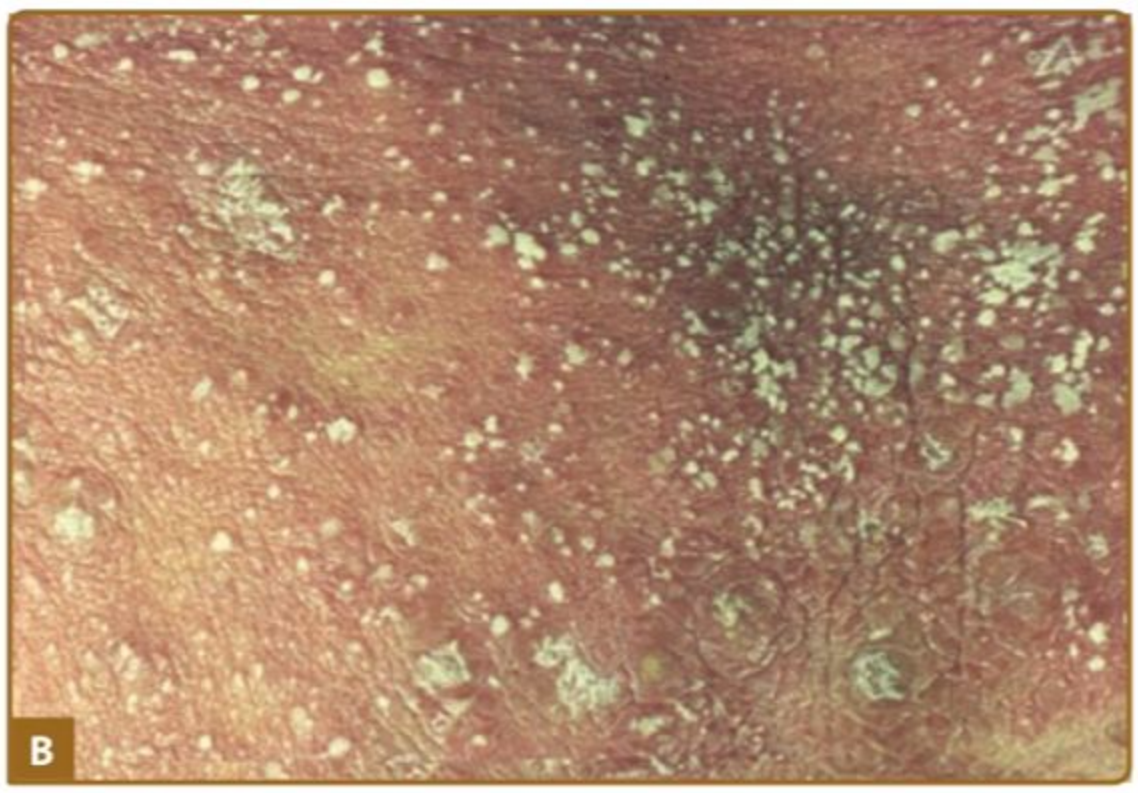


Figure 18-13 Erythrodermic psoriasis. The patient shown in panel **A** rapidly developed near-complete involvement and complained of fatigue and malaise. Note islands of sparing. The patient shown in panels **B** and **C** had total body involvement with marked hyperkeratosis and desquamation. (Photos used with permission from Mr. Harrold Carter and Dr. Johann Gudjonsson.)



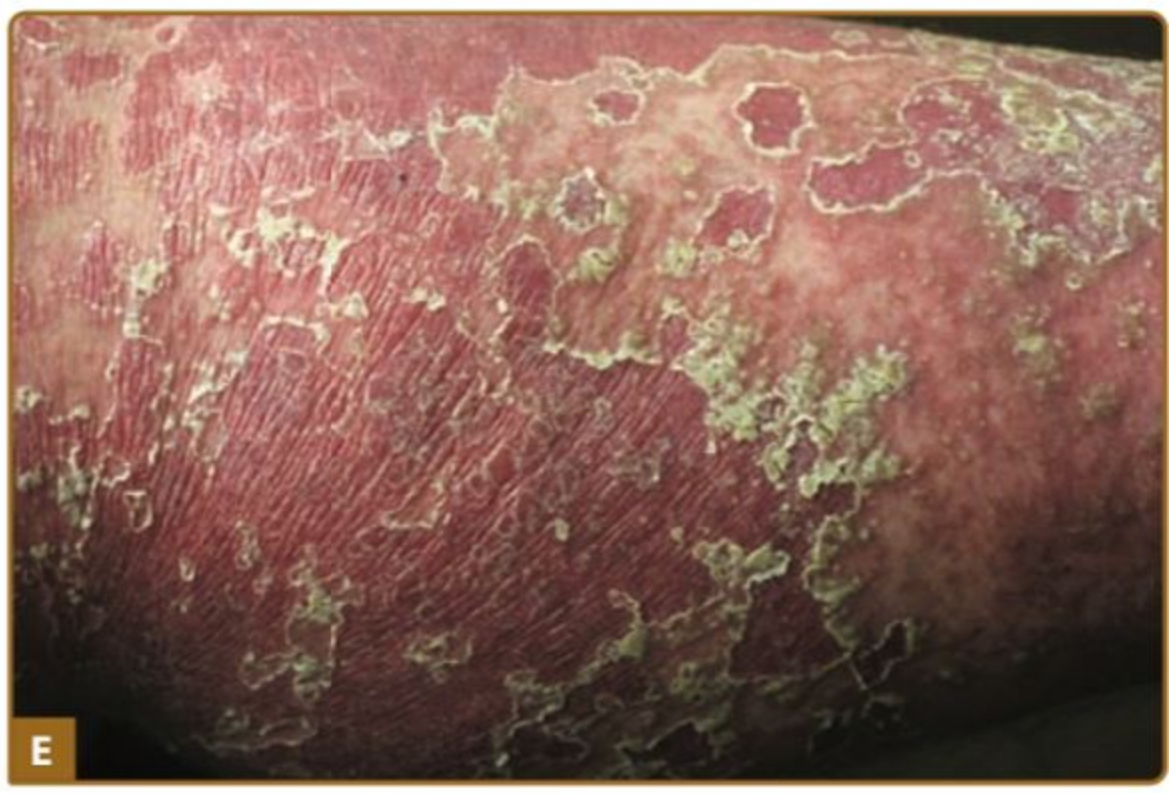


Figure 18-14 Pustular psoriasis. **A** and **B**, von Zumbusch-type generalized pustular psoriasis. Note tiny pustules, 1–2 mm in diameter, on erythematous skin. **C** and **D**, localized pustular psoriasis of the leg and foot, respectively. **E**, resolving pustular psoriasis, note extensive areas of desquamation. (Photos **C**–**E** used with permission from Drs. Johann Gudjonsson, Trilokraj Tejasvi, and Neena Khanna.)

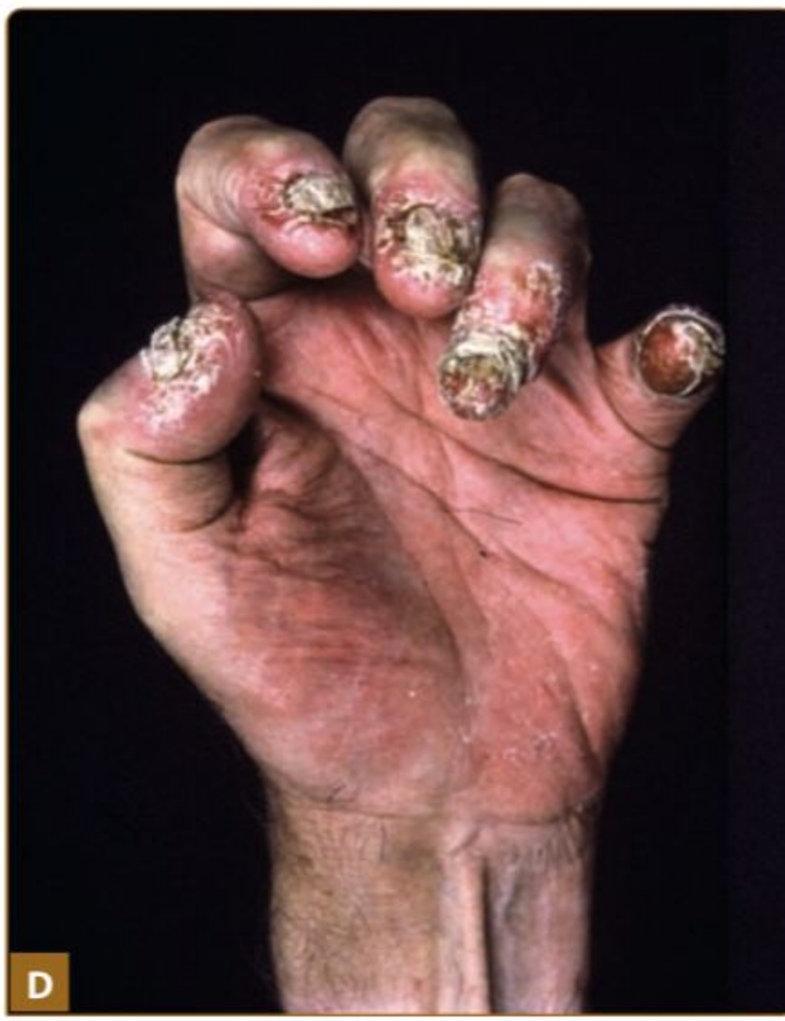


Figure 18-15 Nail psoriasis. Panel **A** demonstrates distal onycholysis and oil drop spotting. Panel **B** dem
onstrates nail pitting. Panel **C** demonstrates subungual hyperkeratosis. Panel **D** demonstrates onychodys
trophy and loss of nails in a patient with psoriatic arthritis. (Photos used with permission from Drs. Johann
Gudjonsson and Allen Bruce, and Mr. Harrold Carter.)

Figure 19-2 Psoriatic nail dystrophy and arthritis of the fifth distal interphalangeal joint (*arrow*) in a patient with psoriatic arthritis.

Figure 22-1 Seborrheic dermatitis in an infant. Widespread pattern of seborrheic dermatitis with psoriasiform lesions on the trunk and groin.

Figure 22-3 Seborrheic dermatitis of the nasolabial fold.

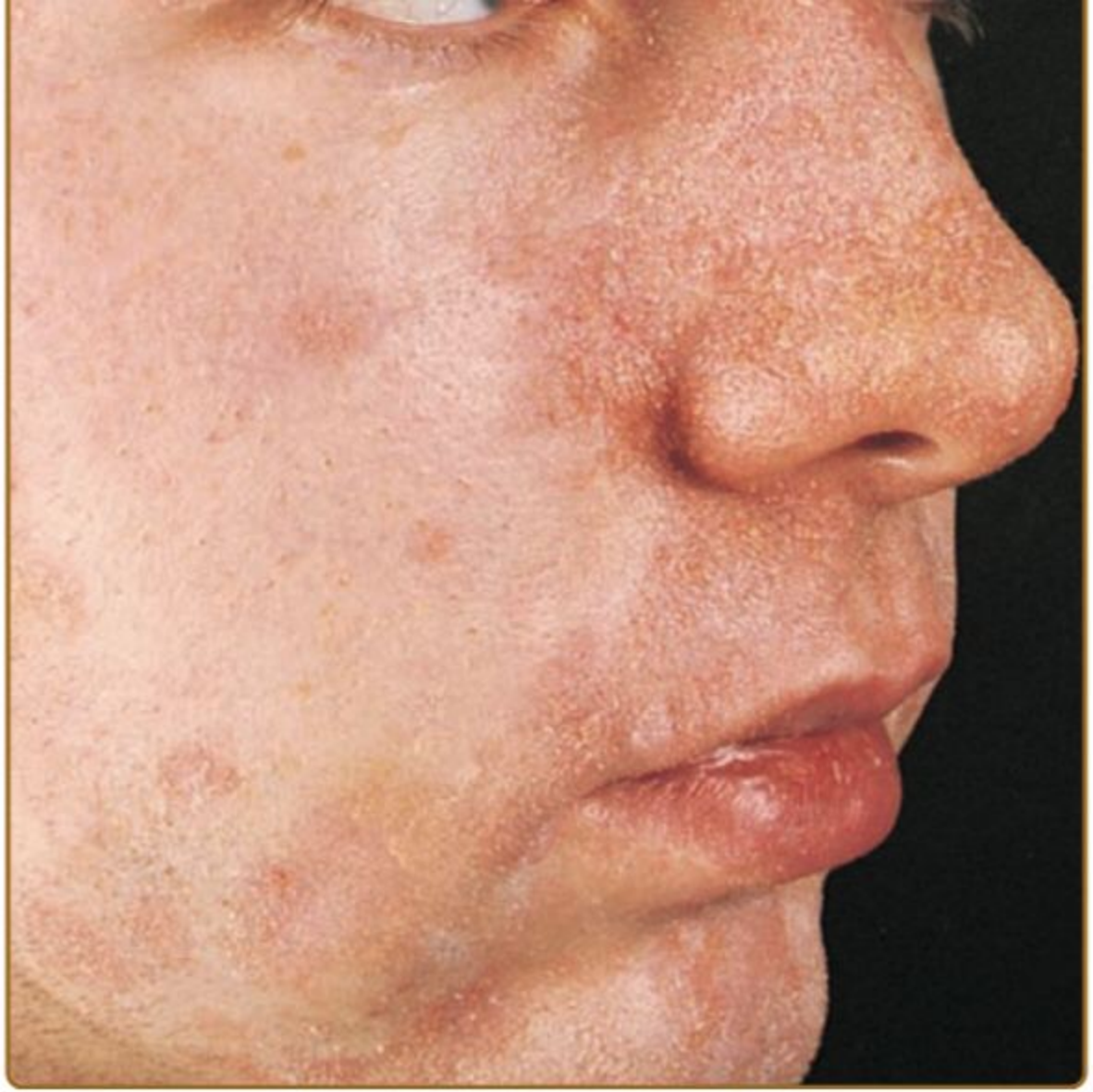


Figure 22-2 Seborrheic dermatitis with involvement of nasolabial folds, cheeks, eyebrows, and nose.

Figure 22-4 Seborrheic dermatitis of the ear: external canal, concha bowl, and auricle.

Figure 22-8 **A** and **B.** Widespread unusual distribution pattern of seborrheic dermatitis in a patient with AIDS. **A.** Moist patches on the centrofacial region, beard and scalp. **B.** Moist lesions on the chest. In patients with AIDS, the disease responds poorly to conventional therapy.

Figure 26-1 Flat-topped, polygonal, sharply defined papules of violaceous color, grouped and confluent. Surface is shiny and reveals fine white lines (Wickham striae). Note pigmentation of resolving lesions.

Figure 26-2 Generalized lichen planus. Small, flat-topp violaceous papules, some grouped, some disseminat becoming confluent on the trunk.

lesions with a magnifying lens or a handheld dermato-

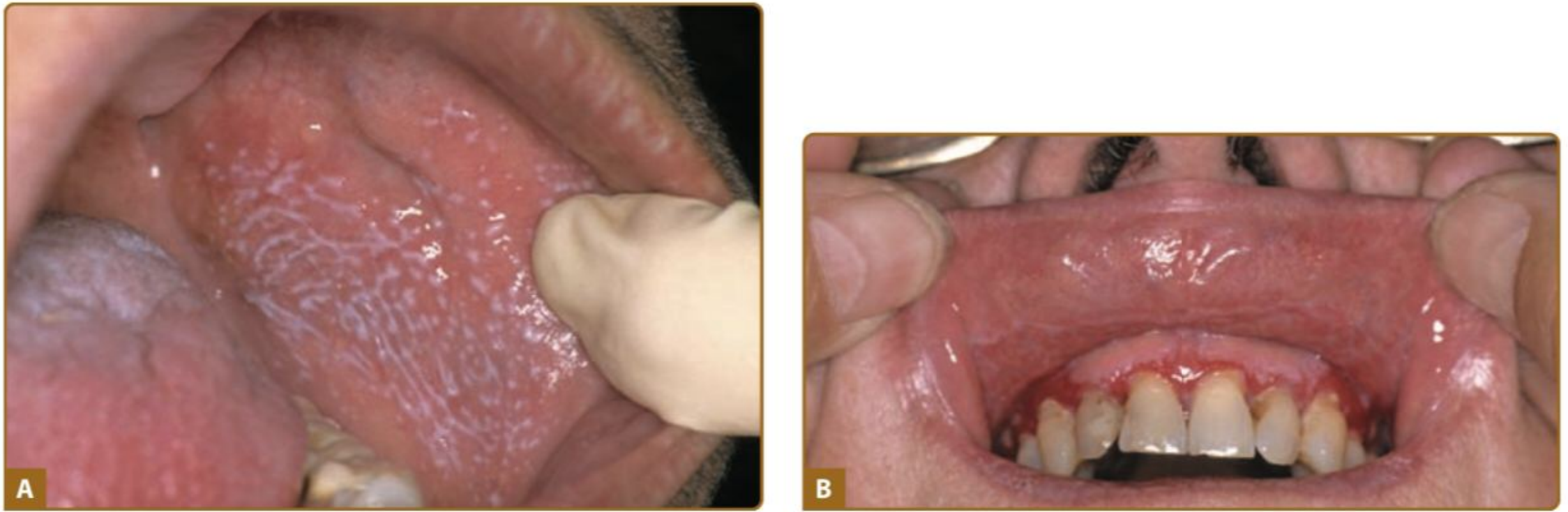


Figure 26-3 Mucosal lichen planus. **A.** A typical lace-like whitish reticulated pattern of oral lesions is seen on the buccal mucosa. **B.** Erosive gingivitis. Here lichen planus manifests as painful erosions on the gingiva.

Figure 26-5 Lichen planus. Linear pattern with Koebner response adjacent to clustered papules on the flexural wrist.

Figure 26-12 Lichen planus. Classic pterygium formation and tenting of several fingers with loss of nail plates.

Figure 38-3 Urticaria and angioedema. This patient has urticaria occurring on the face, neck, and upper trunk with angioedema about the eyes.

Figure 38-6 Lesions of cholinergic urticaria observed in a patient after 15 minutes of exercise in a warm room.

Figure 38-7 Hereditary angioedema. Extensive involvement (**A**) is to be contrasted with the patient's normal facies (**B**)

Figure 39-2 Mixture of typical targets and papules in a case

Figure 39-4 Late lesions of EM with nonspecific blister and erosions but target shapes still visible.

Figure 39-3 Typical target lesions on the palm.

Figure 39-7 Multiple concentric vesicular rings (herpes iris of Bateman). This pattern may be more frequent in *Mycoplasma pneumoniae*-related cases of erythema multiforme major.

Figure 41-5 Fixed drug eruption: tetracycline. A well-defined plaque on the knee, merging with three satellite lesions. The large plaque exhibits epidermal wrinkling, a sign of incipient blister formation. This was the second such episode after ingestion of a tetracycline. No other lesions were present.

Figure 42-3 A double herald patch of pityriasis rosea.

Figure 42-5 Typical distribution of secondary plaques along the lines of cleavage on the back in a Christmas tree pattern.

Figure 42-7 Vesicular pityriasis rosea, showing typica primary plaque and secondary papulovesicles. Not Christmas tree distribution.

Figure 48-1 Irritant contact dermatitis in a welder.

Figure 74-1 Vitiligo vulgaris in an adult.

Figure 74-2 Acrofacial vitiligo.

Figure 74-3 Vitiligo universalis.

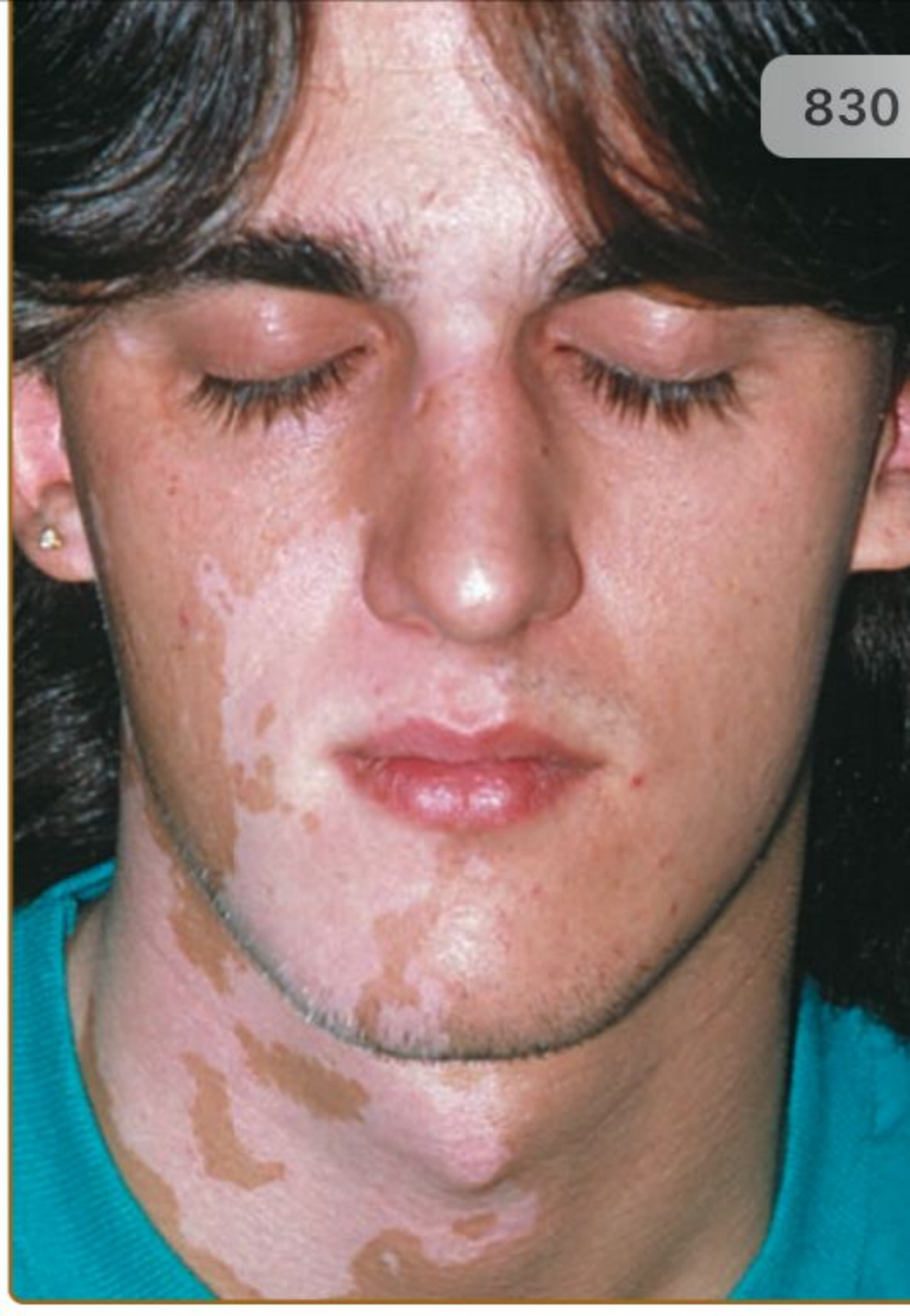


Figure 74-5 Segmental vitiligo of the face and neck

igure 74-4 Focal vitiligo—unique macule of focal vitiligo.

Figure 74-6 Koebnerization under brassiere.

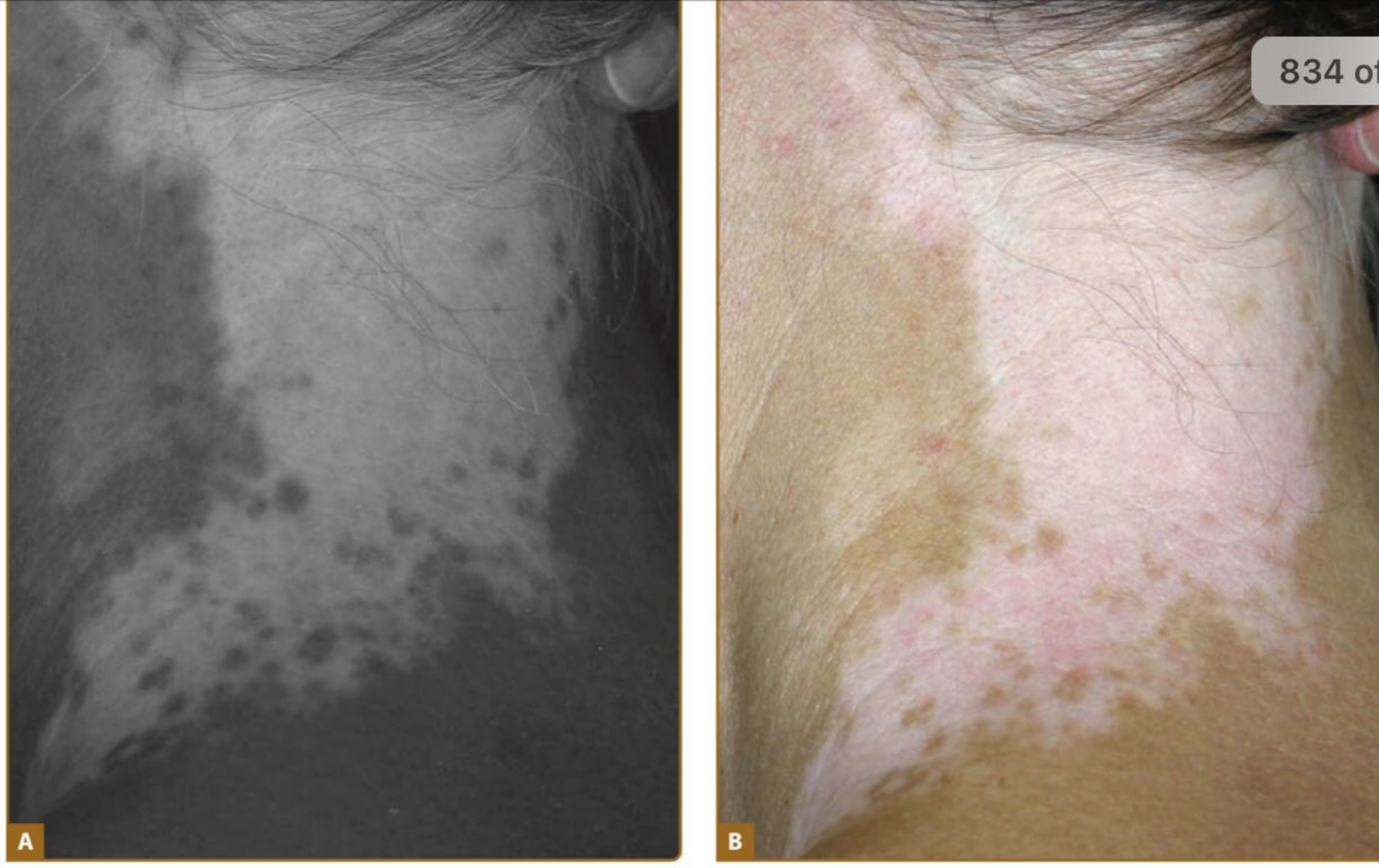


Figure 74-9 Wood's lamp examination. Wood's lamp provides bright reflection of white patches and enhanced detai
on intermediate pigment tones (**A**), as compared with white light (**B**). (Reprinted with permission from Taieb A, Picardo M
Vitiligo. *NEJM* **260**:160-169, 2009.)

Figure 75-4 Pityriasis alba.

Figure 80-3 Clinicopathologic correlation of acne lesions. **A.** Closed comedone. The follicular infundibulum is distende filled with keratin and sebum, and the follicular epithelium is attenuated. The follicular ostium is narrow. **B.** Open com edone. Resembles the closed comedone with the exception of a patulous follicular ostium. **C.** Inflammatory papule. Acut and chronic inflammatory cells surround and infiltrate the follicle, which shows infundibular hyperkeratosis. **D.** Nodul The follicle is filled with acute inflammatory cells. With the rupture of the distended follicle, there is a foreign body granu lomatous response.

Figure 80-4 Acne vulgaris mild. **A.** A 13-year-old girl with mild acne vulgaris. Scattered comedones and/or inflammato lesions are seen, usually limited to less than half of the face. The T-zone of the face is commonly involved. No nodules a present. **B.** An adult female with primarily inflammatory acne. Note the typical involvement of the jawline.

Figure 80-5 Acne vulgaris moderate. **A.** A 15-year-old male with moderate acne is seen. Typically more than half of th is involved with increasing numbers of lesions, usually a mix of lesions is seen: papules, pustules, and comedones quent and limited nodules may be present. Chest and back involvement may also be moderately affected. **B.** A 16-ye female with open and deep closed comedones is pictured. Scarring and postinflammatory changes are possible seq

Figure 80-6 Acne vulgaris severe. **A.** A 17-year-old female with extensive acne is seen. Numerous pustules and nodular lesions admixed with comedones and smaller papules cover the entire face. **B.** Deep, friable nodules that coalesce into pseudocysts are seen in acne conglobata. **C.** Chest and back involvement can be extensive and severe. Scarring is a common complication in severe acne.

Figure 80-8 Acne fulminans. An eruptive form of acne with extensive inflammatory papules and nodules on the ches
(**A**) and back (**B**). Systemic symptoms may accompany this extreme form of acne and scarring is usually quite extensive.

Figure 81-2 **A.** Papulopustular subtype. There is persistent erythema with papules and
pustules. Mild subtype. **B.** Severe form of the papulopustular subtype.

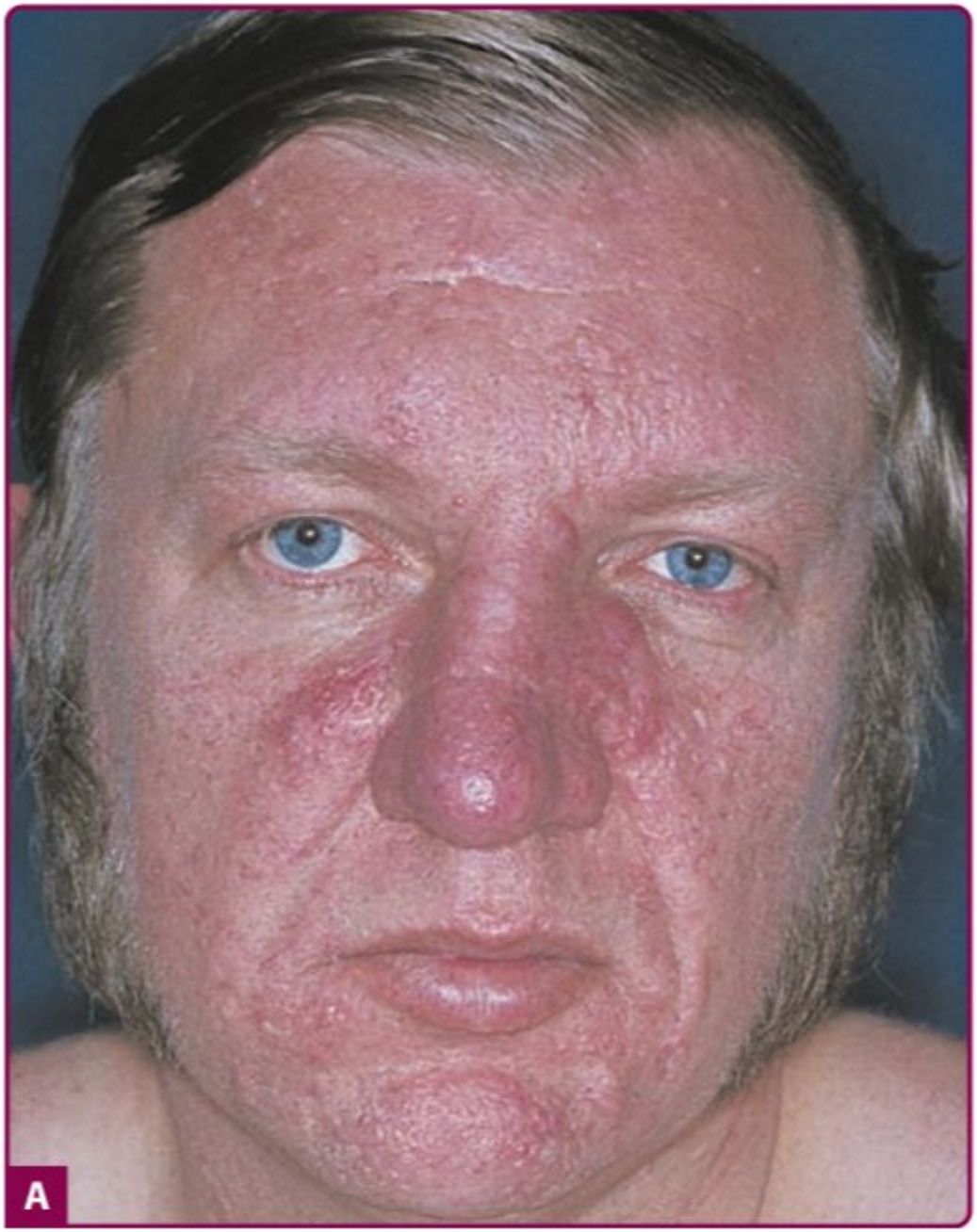


Figure 81-3 **A.** Phymatous subtype. Moderate subtype with patulous follicular orifices, thickened skin, and nodularities on nose and cheeks. **B.** Severe rhinophyma.

Figure 82-1 Typical perioral dermatitis. The eruption is confined to the nasolabial folds and the skin of the chin.

Figure 82-2 Perioral (granulomatous periorificial) dermatitis. This child shows the typical small papules studding the area around the mouth and eyes.

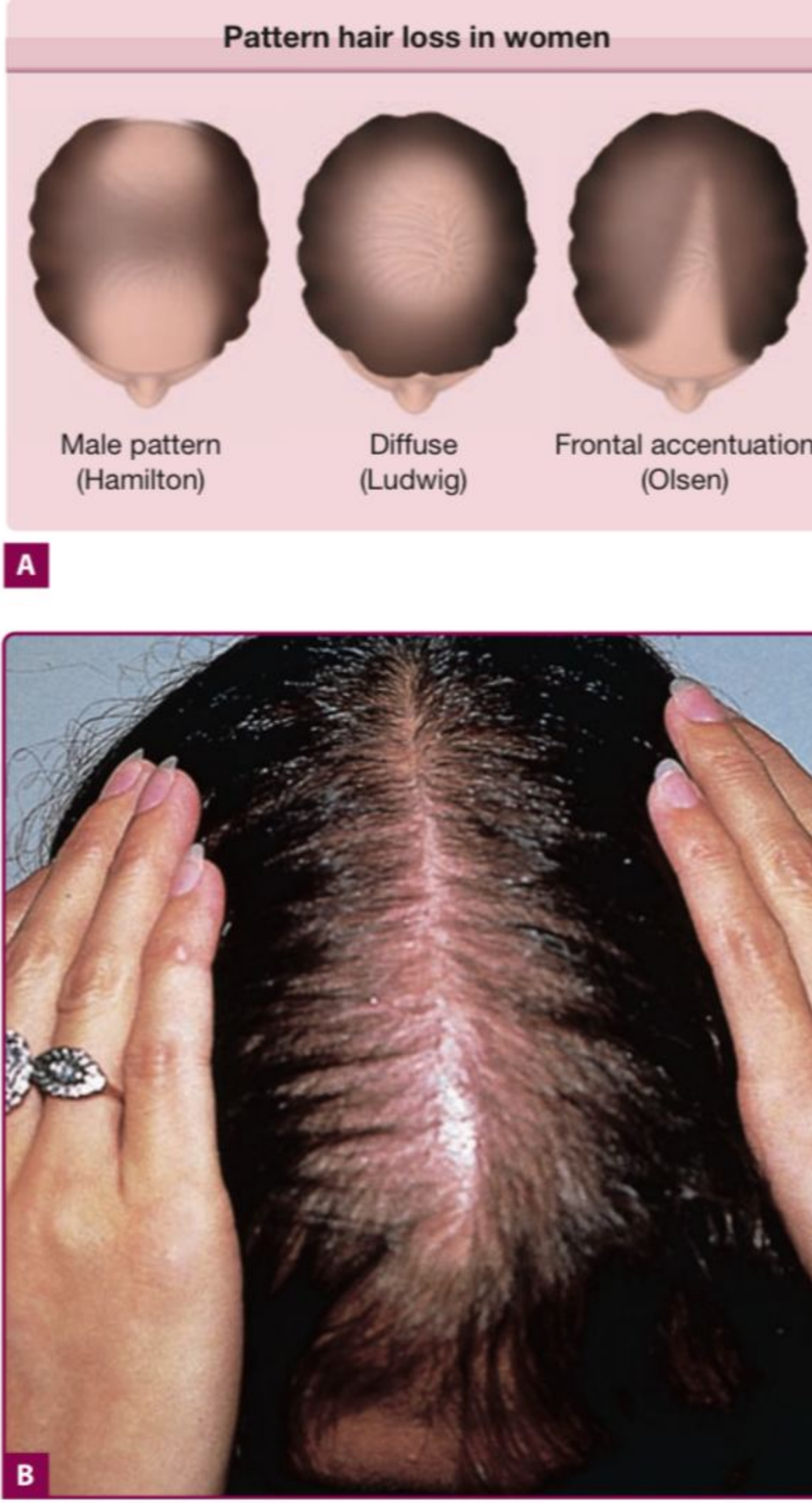


Figure 88-5 Pattern hair loss in women. **A.** Different phenotypic expressions. **B.** Characteristic frontal accentuation (widened hair part). (From Wolff K, Goldsmith LA, Katz SI, Gichrest BA, Paller AS: Fitzpatrick's Dermatology in General Medicine. 7th ed. Copyright © The McGraw-Hill Companies, Inc. All rights reserved, with permission.)

Figure 88-10 Diffuse thinning in a female patient with acute telogen effluvium.

igure 88-11 Patient with patchy alopecia areata.

Figure 188-4 "Black dot" tinea capitis caused by *Trichophyton tonsurans*.

from follicular pustules to furunculosis (Fig. 188-5) or kerion (Fig. 188-6). Intense inflammation may also

Figure 188-6 Kerion of the scalp.

Figure 188-8 Tinea barbae. **A.** Superficial type. Scattered follicular pa
mistaken for *Staphylococcus aureus* folliculitis. **B.** Kerion type. Sharp

Figure 188-9 Tinea corporis. **A.** Annular. Tinea corporis demonstrating the classic annular or "ring worm" like configuration and advancing raised erythematous and scaly border. Note that because the dorsum of the foot is predominantly involved, this eruption is considered tinea corporis and not pedis. **B.** Polycyclic. Tinea corporis demonstrating multiple polycyclic red erythematous plaques with a raised scaly border. **C.** Psoriasiform. Tinea corporis resembling psoriasis.

Figure 188-12 Tinea pedis. **A.** Interdigital type. The inderdigital space is macerated with opaque white scales and has erosions. **B.** Moccasin type. Patchy erythema and scaling in a moccasin distribution on the foot. The arciform pattern of scales is characteristic. **C.** Bullous type. Ruptured bullae, erosions and erythema on the plantar aspect of the great toe. Hyphae were detected on KOH 10% preparation obtained from epithelial cell on the roof of the inner aspect of the bulla.

Figure 188-13 Tinea pedis and manus. "Two feet–one hand" presentation of *Trichophyton rubrum*. Scaling in the involved (*right*) hand is accentuated in the creases.

Figure 188-14 Tinea unguium. **A.** Distal subungual type. Discoloration, thickening and subungual debris of the distal aspect of the toenails. **B.** Proximal subungual type. Discoloration and thickening of the proximal nail in a patient with acquired immunodeficiency syndrome; Kaposi sarcoma is also seen on the fourth toe. **C.** White superficial type. Irregular opaque white patches on various parts of the nail plates.

Figure 189-1 **A.** Pseudomembranous candidiasis or thrush. Note the characteristic white patches on the palate. **B.** Atrophic candidiasis under dentures. Edema and erythema at the site of contact with dentures. **C.** *Candida* perlèche with erythema and fissuring at the corners of the mouth. **D.** Hyperplastic candidiasis of the tongue.

Figure 189-4 Candidal intertrigo. **A.** Erythematous, eroded, pustular papules coalescing to plaques involving the scrotu and inguinal area with satellite lesions. Collarette-like scales where pustules have eroded. **B.** Confluent and discrete e thematous, eroded areas with pustular and erosive satellite lesions. **C.** Red, partially eroded plaques on the vulva su rounded by a delicate collarette in an infant. Outside the main lesions are a few pustular satellite lesions. **D.** Erosio int digitalis blastomycetica. Erythematous eroded areas between the fingers.

Figure 189-7 Chronic onychia and paronychia caused by *Candida albicans*. **A.** Note the warm but not hot, slightly tender, edematous nail fold with some onycholysis. This is very often misdiagnosed as staphylococcal paronychia. **B.** This is a chronic inflammatory condition with pustulation of the nail fold that also can involve the nail plate.

Figure 189-11 Pityriasis (tinea) versicolor. Macules and patches may have a wrinkled surface appearance.

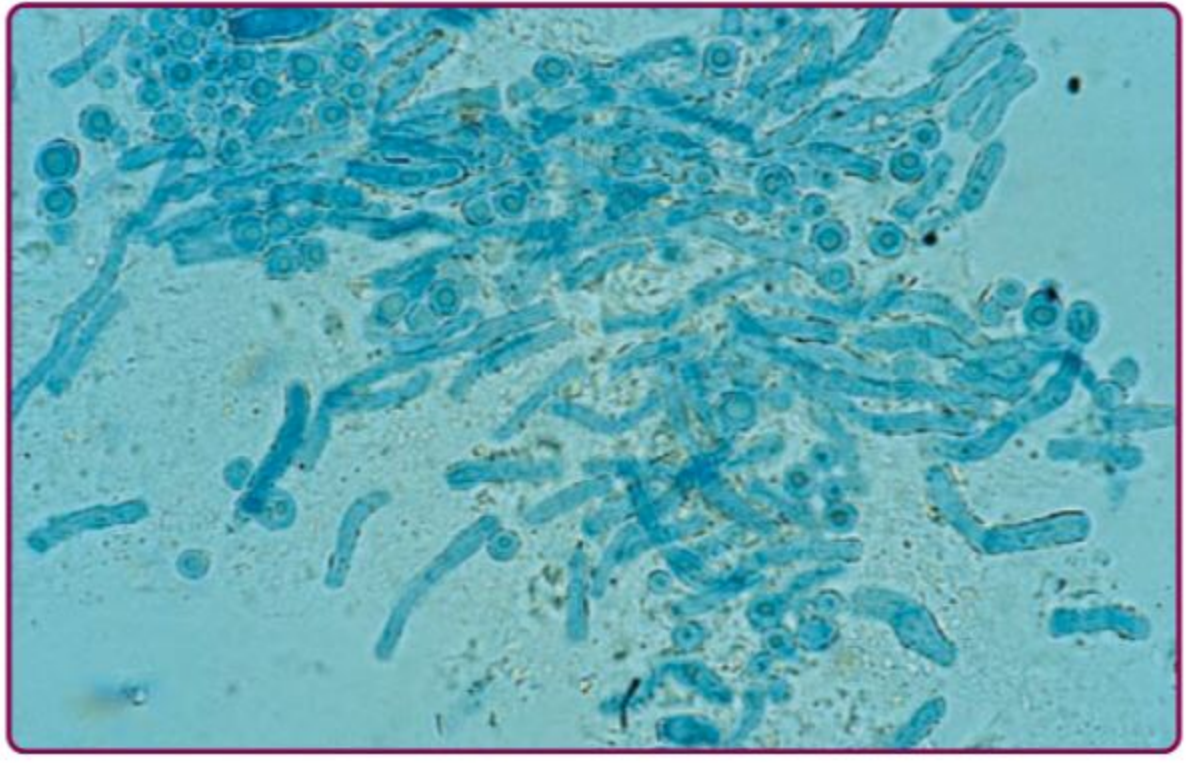


Figure 189-12 "Spaghetti and meatballs" appearance of *Malassezia* in a KOH preparation.

Figure 193-1 Primary herpetic gingivostomatitis. (Used with permission from Clyde S. Crumpacker, MD.)

ulcerative lesions involving the hard and soft palate, tongue, and buccal mucosa, as well as neighboring

Figure 193-3 Recurrent facial herpes simplex wi grouped vesicles and crusting. (Used with permissio from Clyde S. Crumpacker, MD.)

Figure 193-7 Herpes simplex virus infection: herpetic whitlow. Painful, grouped, confluent vesicles on an erythematous edematous base on the distal finger were the first (and presumed primary) symptomatic infection.

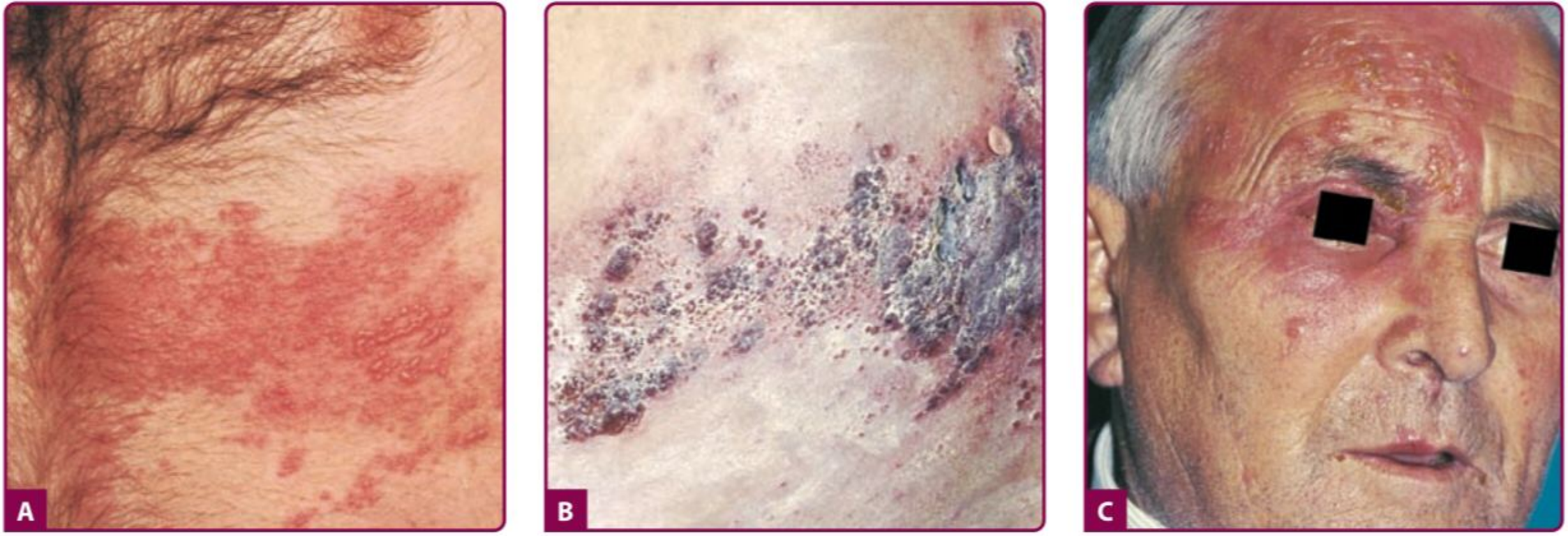


Figure 194-4 Herpes zoster. **A.** Early involvement of a thoracic dermatome with erythema within the dermatome and areas of grouped vesicle formation. **B.** Later involvement with crusted sites on the back, where the eruption first appeared, and many confluent hemorrhagic vesicles and bullae on the lateral chest wall, where the eruption appeared more recently; some vesicles are also seen outside the involved dermatome, representing hematogenous dissemination, a not uncommon occurrence. **C.** Ophthalmic zoster. Note the involvement of the tip of the nose, which frequently signals involvement of the eye.

Figure 196-8 Plane warts, verruca plana. **A.** Multiple pink flat warts on the face of an 11-year-old girl. **B.** Many flat-topped papules occur in a linear configuration resulting from self-inoculation.

Figure 196-10 Epidermodysplasia verruciformis. Plane wart-like lesions on the dorsa of the hands and forearms, associated with human papillomavirus-5 and -8. The lesions are numerous, flat, reddish, and partly confluent.

Figure 206-1 **A**. Acute Old World-localized cutaneous leishmaniasis: multiple nodules on the arm caused by *Leishma*
major. **B.** Multiple, nodular, ulcerated lesions on the trunk at the site of sand fly bites. Note that the ulcerated nodules lo
similar to volcanoes seen from above ("volcano sign").

Figure 206-2 Acute Old World-localized cutaneous leishmaniasis. Single crusted erythematous plaque over the cheek.

Figure 206-4 Acute Old World-localized cutaneous leishmaniasis. Crusted and ulcerated erythematous papule over the scalp.

chancriform, annular, palmoplantar,[57] verrucous, and

Figure 206-3 Acute Old World-localized cutaneous leishmaniasis. Crusted erythematous nodule over the right perioral area in a young Middle Eastern girl.

Figure 206-5 **A** and **B.** Acute Old World-localized cutaneous leishmaniasis. Classical "volcaniform" noduloulcerat lesion over the forearm.

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